STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445297	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHHAVEN HEALTH CARE CENTER	3300 BROADWAY NE KNOXVILLE, TN 37917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure hazardous area ' s fire rated construction is maintained. The findings include: Observation and interview with the Maintenance Director, on October 12, 2011 at 11:45 a.m. confirmed unsealed penetrations above the 90-minute fire door by room 217 and above the basement Central Supply room door at a conduit penetration.	K 029	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K 029 It is the practice of this facility to ensure that all smoke resisting partitions and doors are in compliance at all times. The penetration at the Central supply room door did have fire caulk present, but was redone to meet the standards on 10/18/11. The area above the fire door at room 217 will be completed by Life Safety Services by 11/18/11. Maintenance supervisor will monitor all work to ensure that the unsealed penetrations are properly corrected to meet the code guidelines. Preventative Maintenance program will include review of these identified areas for penetrations on a monthly basis. The maintenance supervisor will report the results of the preventative maintenance logs to the facility performance improvement committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Activities Director, Case Manager, Medical Director, and Maintenance Supervisor) at least quarterly during the monthly meeting for review and recommendations as indicated.	11/18/11
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tracy Durham	Administrator	10/28/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 052	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure smoke detectors were located at least 1 foot and no more than 5 feet from either side of a fire door (NFPA 72, 2-10.6.5.1.1). The findings include: Observation and interview with the Maintenance Director, on October 12, 2011 at 10:45 a.m. confirmed no smoke detectors were within 5-feet of the fire doors by rooms 112 and 215. Based on observation and interview, the facility failed to assure door release devices were not powered by a secondary power supply.(NFPA 72-3-9.7.3) The findings include: Interview with the Maintenance Director, on October 12, 2011 at 1:45 p.m. confirmed the magnetic locking hardware power supply was also supplied from the emergency generator.	K 052	K 052 It is the practice of this facility to ensure that all smoke detectors are located at least 1 foot and no more than 5 feet from either side of a fire door and that door release devices are not powered by a secondary power supply. The smoke detectors were installed and completed by Simplex Grinnel on 10/26/11. Maintenance supervisor monitored the placement of the smoke detectors to ensure that they were properly installed and operating correctly. Magnetic door locking hardware does disengage when the fire alarm system is activated. This occurs regardless of whether the facility is operating on normal power or on emergency generator power. The facility will make any and all applicable changes to the magnetic door locking system if required once the BLHCF issues their final ruling. The fire alarm system is checked professionally on a quarterly basis which includes the smoke detectors. Maintenance supervisor will report the results of the fire alarm system check to the performance improvement committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Activities Director, Case Manager, Medical Director, and Maintenance supervisor) at least quarterly during the monthly meeting for review and recommendations as indicated. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	11/18/11
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	K062 It is the practice of this facility to ensure that the sprinkler system is not being used to support any non-system components. The wiring above the lay in ceiling by the stairwell door and room 211 was removed from the sprinkler piping by 10/18/11.	11/18/11

OCT 28 2011

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K 062	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure the sprinkler system was not used to support non-system components. (NFPA 13, 9-1.1.7) The findings include: Observation and interview with the maintenance director, in the corridor, on October 12, 2011 at 10:45 a.m.. wiring above the lay in ceiling by the stairwell door and room 211 was attached to or supported by sprinkler piping .	K 062	Maintenance supervisor and assistant checked all sprinkler piping throughout the building to ensure that there was no wiring attached to the sprinkler pipes by 10/18/11. Preventative maintenance program will include review of all sprinkler piping to ensure that wiring remains removed on a quarterly basis. Maintenance supervisor will report the results of the sprinkler system check to the performance improvement committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Activities Director, Case Manager, Medical Director, and Maintenance Supervisor) at least quarterly during the monthly meeting for review and recommendations as indicated. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure commercial cooking equipment had a drip tray that drained into an enclosed metal container having a capacity not exceeding 1 gal (NFPA 96, 3-2.6). The findings include: Observation and interview with the Maintenance Director, on October 12, 2011 at 10:45 a.m. confirmed there was no enclosed metal container to contain grease below the cooking hood.	K 069	K 069 It is the practice of this facility to ensure that any commercial cooking equipment have a drip tray that drains into an enclosed metal container having a capacity not exceeding 1 gallon. The enclosed metal container that contains any grease below the cooking hood was installed on 10/24/11. The grease trap will be checked with each hood filter cleaning which will be done on a monthly basis. The dietary employee or designee assigned to clean the hood filters will check and document on the cleaning schedule when completed. Maintenance supervisor will check quarterly with preventative maintenance program and report any issues to the performance improvement committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Activities Director, Case Manager, Medical Director, and Maintenance Supervisor) at least quarterly during the monthly meeting for review and recommendations as indicated.	11/18/11
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 073		

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K 073	Continued From page 3 failed to assure combustible decorations had documentation to show they were treated with a fire retardant (NFPA 110, 19.7.5.4). The findings include: Observation and interview with the Maintenance Director, on October 12, 2011 between 10:00 a.m. and at 2:00 p.m. confirmed the facility failed to provide documentation that indicated decorations and quilts in the corridors were treated with fire retardant material.	K 073	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K 073 It is the practice of this facility to ensure that combustible decorations be treated with a fire retardant and have supporting documentation of this. Maintenance supervisor will have documentation completed on decorations and quilts in the corridors that show that they have been treated with fire retardant material as per regulations by 10/31/11. Each applicable item will be tagged and logged when treated. Any decorations that are brought in for use in the common areas will be treated with fire retardant, logged and tagged as indicated. Maintenance supervisor will check quarterly with preventative maintenance program and report any issues to the performance improvement committee (Administrator, DNS, ADNS, SDC, RD, Social Services, Activities Director, Case Manager, Medical Director, and Maintenance Supervisor) at least quarterly during the monthly meeting for review and recommendations as indicated.	11/18/11